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	155348	A. BUILDING _____ B. WING _____	02/25/2011

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PARKVIEW CARE CENTER	2819 NORTH ST JOSEPH AVENUE EVANSVILLE, IN47720

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F0000	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00086322. Complaint IN00086322-Substantiated, Federal/State deficiencies related to the allegations are cited at F225, F226, F241, F282 and F312. Survey Dates: February 21, 22, 23, 24, 25, 2011 Facility Number: 000239 Provider Number: 155348 AIM Number: 100290150 Survey Team: Jodi Meyer, RN, TC Diane Hancock, RN Guylene Maurer, RD [2/21-23/11] Census Bed Type: SNF/NF = 83 Total = 83 Census Pay Type: Medicare = 12 Medicaid = 50 Other = 21 Total = 83 Sample: 17	F0000	Please accept this Plan of Correction as my credible allegation of compliance. I also respectfully request this Plan of Correction be accepted as paper compliance of the alleged deficiencies. This Plan of Corection is submitted under Federal and State regulations and statutes applicable to long term care providers. This Plan of Correction does not constifute an admission of liability on the part of the facility, and such liability is hereby specifically denied. the submission of this Plan does not constitute agreement by the facility that the surveyor's findings or conslusion are accurate, constitute deficiency or that the scope and severity regarding any of the deficiencies cited are correctly applied.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Supplemental sample: 9 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.			

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F0225 SS=E	Based on record review and interview, the facility failed to report and investigate each allegation of mistreatment of residents by facility staff; in that, 4 of 4 supplemental sample residents [V, W, X, Z] who complained of mistreatment and/or roughness by CNA #2, in the supplemental sample of 9, failed to have their allegations fully investigated and reported, resulting in the CNA continuing to work at the facility and interact with residents. Findings include: 1. On 2/22/11 at 11:00 a.m., the employee file of CNA #2 was reviewed. The employee's hire date was 7/25/07 with reinstatement after maternity leave of August 2008. The file contained fifteen corrective action forms and/or one on one training of the employee. Four corrective actions were in regards to neglect and/or poor care of residents, with dates ranging from October 2008 to April 2010. Corrective action, dated 4/14/10, indicated, "Residents complaints of rudeness, being rough and improper care." Two therapists and a CNA provided written statements of the residents' concerns of the events that occurred on 4/5 or 4/6 and 4/8/10, as follows:	F0225	1. C.N.A. #2 was suspended immediately pending investigation. Nursing Administration was inserviced by the Executive Director regarding ISDH reporting regulation including immediately notifying the Executive Director and timely reporting to appropriate agencies. 2.Interviews conducted with interviewable residents who had been cared for by cna #2 regarding care & treatment performed by any associates. No allegations of mistreatment and/or roughness were reported during interviews. Licensed Nurses were inserviced by Staff Develpment coordinator on 2/22/11 regarding ISDH reporting regulation. Cnas were inserviced on 2/22/11 by SDC regarding ISDH reporting regulation. 3. Executive Director will receive verbal report daily 7 days a week from Nursing Administration on any allegations of mistreatment and/or roughness of resident by facility staff. There will be continued ongoing education of residents, upon admission and quarterly during Resident Council by SSD, of new associate hires by SSD, and all associates quarterly by SDC. Any reports of mistreatment 7/or roughness will be reported immediately to the Executive Director.4. Audits will be completed by Nursing Administration and the Executive Director daily, 7 days a week for 3	03/27/2011

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	Recorded on 4/9/10 by Physical Therapist #1, regarding Resident X, "[name of PT] please don't tell no body but would you like it if they wash your face then go to bottom then go back up to your face?...I 'am not going to name no one but I just don't do that at home, but you know, I take a shower all the time before this happened.' Conversation happened on Monday or Tuesday 4/5 or 4/6/10." Recorded on 4/9/10, by Occupational Therapist Assistant #1, regarding Resident X, "4/8/10 Resident found tearful and upset after bath, with patient stating, 'that girl gave me a hard time about my colostomy'. " Recorded on 4/9/10, by CNA #6 regarding Resident W and Resident V, "On Friday April 9, 2010 [name of OTA#1] approached me in the hallway and told me that Resident W had been upset the previous day, April 8, 2010. She said that CNA #2 had been her aide that day and Resident W stated to her that CNA #2 was very rude to her and had raised her voice with her. [name of OTA#1] told me Resident W was very upset and crying over the situation. Later on during this day, April 9, 2010, Resident V had told me that she also had		months to ensure all allegations of mistreatment and/or roughness of residents are investigated and reported. Audits will continue to be completed 5 times a week for 3 months, then 2 times a week for 6 months. Audit findings will be reviewed by the PI committee monthly, for 12 months. PI Committee will determine need for further audits. Plans will be updated as indicated.	

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	CNA #2 as an aide the previous day. Resident V told me ' I didn't know CNA#2 could be so mean. She done a lot of yelling and was mean yesterday.' I told my nurse, LPN #5 of the two incidents and she had me write this statement and said she would take care of it." LPN #5 recorded on 4/9/10, "After a RCT [CNA] reported to me 2 of her residents were c/o [complaining of] [name of] CNA #2 being 'mean to me' I spoke with the residents. Resident V stated that [name of] CNA#2 was hateful to her and acted like she didn't want to be bothered with her. When questioned as to what [name of] CNA#2 said, Resident V stated 'it wasn't what she said but how she said it.' I then spoke with Resident W, she stated [name of] CNA#2 had an 'attitude' with her and was hateful and this made her feel bad. She then stated 'she was so short with me.' She c/o [name of] CNA #2 to therapy. I then spoke with Resident X who had c/o [name of] CNA #2 to therapist. Resident stated she didn't like the way she gives her a bath because she doesn't get between her legs good and she will wash her face with same cloth she washed her peri area with. She also states that [name of] CNA#2 is very short with her."			

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The corrective Action form was recorded on the back, "In the event of further corrective action in this or another area of performance, you will be subject to the corrective action below, including but not limited to; Termination." The form was signed by the CNA #2 and LPN # 1.

The allegations were not reported to the State agency, or fully investigated to include other resident or staff interviews. The corrective action form was not reviewed and/or signed by the Administrator.

During an interview with the Administrator, on 2/23/11 at 10:15 a.m., she was unaware of how the allegation was missed and not been reported regarding residents X, V, W.
At that time, a grievance report with the missing item log was provided by the Administrator. The grievance report indicated Resident Z had complained of being "manhandled" during care by CNA #2 and that she was sore following the care on 12/16/10. She indicated it was the same CNA as in the other allegation.

The grievance investigation indicated the following:
Housekeeping Assistant #1 provided a

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	written statement on 12/16/10, regarding Resident Z, "[name of housekeeping assistant #1] was walking down Dogwood hall at 10:00 a.m. [name of] Resident Z was sitting outside her room in the hallway. [name of] Resident Z asked me who was working today. I told [name of] Resident Z I saw [name of two CNAs] down the hall. Resident Z said, 'I am sore from them getting me up this morning.' I asked Resident Z who got her up. Resident Z said, ' I don't know who she was but she manhandled me and now I am sore.' I asked her if she knew what time she got up and she said it was early. Resident Z was rubbing her hip and lower stomach area. I went and reported this to my supervisor and we reported to [name of] Administrator." A document written by RN #2 in the grievance investigation, on 12/16/10, indicated in a typed time line/statement the following: "9:50 a.m.-Received report that resident was in need of an interview due to some concerns that had been voiced. 10:05 a.m.- Resident in activity at this time spoke with me briefly. Resident was asked if she was upset this AM by something. Resident stated that she was upset & someone was rushing with her this AM. I asked resident to speak with			

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	me after her activity was finished. 10:30 a.m.- Resident came to my office & stated that she needed to talk to me now. I asked resident to tell me about what had happened this AM that upset her. She proceeded to tell me that nobody was mean to her, but they were just rushing around when they got her dressed & up for the day- 'I felt like they were just man-handling me.' Resident stated that she was not mad & did not want anybody in trouble. She stated to just 'ask them to slow down & tell me what is going on.' Resident then stated that the girl that got her up today sat in her lap this morning when she was getting her ready for the day. Resident showed this nurse how someone had sat across her lap. Resident stated that she again did not want anyone in trouble about this--she stated maybe they were just rushing because of the snow outside. 10:45 a.m.-Skin assessment done... No complaints of pain...." CNA #2's written statement for this incident was as follows: "I and an oriente [sic] walked into room got clothes pan out went to hall to get supplies. Resident stated she didn't want to be washed. I said YES I washed her up got her transferred to w/c [wheel chair] stripped bed left room."			

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	RN #2, at 3:00 p.m. on 12/16/10, recorded five areas of work improvement with CNA #2 in regards to the above Resident Z allegations. None of Resident Z's allegations had been reported to State agencies and/or investigated thoroughly. The above interactions and/or work improvements for CNA #2 were not part of CNA #2 's employee record or work history. This federal tag relates to complaint number IN00086322. 3.1-28(c)			

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F0226 SS=E	Based on record review and interview, the facility failed to follow their policy for investigation and reporting allegations of abuse, for 2 of 2 allegations of mistreatment and rough handling reviewed and alleged to have occurred from one CNA (#2). This affected 4 of 4 supplemental sample residents [V, W, X, Z] who complained of mistreatment and/or roughness by CNA #2, in the supplemental sample of 9. Findings include: 1. The Administrator provided the "Abuse and Neglect Policy" on 2/21/11 at 2:00 p.m. Item 10 indicated. "The revised reporting protocol 4/1/06 for state regulations and Parkview Care Center policy will be followed." "The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures." The policy was not followed regarding reporting and /or investigating for the following allegations:	F0226	1.Nursing Administration was inserviced by the Executive Director regarding ISDH reporting regulation including immediately notifying the Executive Director and timely reporting to appropriate agencies.2. Facility Policy/Procedure was revised and updated on 3/7/11 to meet regulatory intent. Nursing Admin. and Licensed Nurses inserviced on 3/8/11 regarding following policy of the facility.3. The Executive Director will receive verbal report 7 days a week from Nursing Admin on any allegations of mistreatment and/or roughness of residents by the facility staff. There will be continued ongoing education of residents upon admission and quarterly during Resident Council by SSD, of new associate hires by SSD, and all associates quarterly the the SDC.4. Audits will be completed by Nursing Admin. and the Executive Director daily, 7 days a week, for 3 months to ensure all allegations of mistreatment and/roughness of residents are investigated and reported. audits will continue to be completed 5 times a week for 3 months, then 2 times a week for 6 months. audit findings will be reviewed by the PO Committee monthly, for 12 months. PI Committee will determine need for further audits. Plans will be updated as indicated.	03/27/2011

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	On 2/22/11 at 11:00 a.m., the employee file of CNA #2 was reviewed. The employee's hire date was 7/25/07 with reinstatement after maternity leave of August 2008. The file contained fifteen corrective action forms and/or one on one training of the employee. Four corrective actions were in regards to neglect and/or poor care of residents, with dates ranging from October 2008 to April 2010. Corrective action, dated 4/14/10, indicated, "Residents complaints of rudeness, being rough and improper care." Two therapists and a CNA provided written statements of the residents' concerns of the events that occurred on 4/5 or 4/6 and 4/8/10, as follows: Recorded on 4/9/10 by Physical Therapist #1, regarding Resident X, "[name of PT] please don't tell no body but would you like it if they wash your face then go to bottom then go back up to your face?...I 'am not going to name no one but I just don't do that at home, but you know , I take a shower all the time before this happened.' Conversation happened on Monday or Tuesday 4/5 or 4/6/10." Recorded on 4/9/10, by Occupational Therapist Assistant #1, regarding Resident X, "4/8/10 Resident found tearful and			

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	upset after bath, with patient stating, 'that girl gave me a hard time about my colostomy.'" Recorded on 4/9/10, by CNA #6 regarding Resident W and Resident V, "On Friday April 9, 2010 [name of OTA#1] approached me in the hallway and told me that Resident W had been upset the previous day, April 8, 2010. She said that CNA #2 had been her aide that day and Resident W stated to her that CNA #2 was very rude to her and had raised her voice with her. [name of OTA#1] told me Resident W was very upset and crying over the situation. Later on during this day, April 9, 2010, Resident V had told me that she also had CNA #2 as an aide the previous day. Resident V told me 'I didn't know CNA#2 could be so mean. She done a lot of yelling and was mean yesterday.' I told my nurse, LPN #5 of the two incidents and she had me write this statement and said she would take care of it." LPN #5 recorded on 4/9/10, "After a RCT [CNA] reported to me 2 of her residents were c/o [complained of] [name of] CNA #2 being 'mean to me' I spoke with the residents. Resident V stated that [name of] CNA#2 was hateful to her and acted like she didn't want to be bothered with			

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	her. When questioned as to what [name of] CNA#2 said, Resident V stated 'it wasn't what she said but how she said it.' I then spoke with Resident W, she stated [name of] CNA#2 had an 'attitude' with her and was hateful and this made her feel bad. She then stated 'she was so short with me.' She c/o [name of] CNA #2 to therapy. I then spoke with Resident X who had c/o [name of] CNA #2 to therapist. Resident stated she didn't like the way she gives her a bath because she doesn't get between her legs good and she will wash her face with same cloth she washed her peri area with. She also states that [name of] CNA#2 is very short with her." The corrective Action form was recorded on the back, "In the event of further corrective action in this or another area of performance, you will be subject to the corrective action below, including but not limited to; Termination." The form was signed by the CNA #2 and LPN # 1. The allegations were not reported to the State agency, or fully investigated to include other resident or staff interviews. The corrective action form was not reviewed and/or signed by the Administrator.			

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	During an interview with the Administrator, on 2/23/11 at 10:15 a.m., she was unaware of how the allegation was missed and not been reported regarding residents X, V, W. At that time, a grievance report with the missing item log was provided by the Administrator. The grievance report indicated Resident Z had complained of being "manhandled" during care by CNA #2 and that she was sore following the care, on 12/16/10. She indicated it was the same CNA as in the other allegation. The grievance investigation indicated the following: Housekeeping Assistant #1 provided a written statement on 12/16/10, regarding Resident Z, "[name of housekeeping assistant #1] was walking down Dogwood hall at 10:00 a.m. [name of] Resident Z was sitting outside her room in the hallway. [name of] Resident Z asked me who was working today. I told [name of] Resident Z I saw [name of two CNAs] down the hall. Resident Z said, 'I am sore from them getting me up this morning.' I asked Resident Z who got her up. Resident Z said, ' I don't know who she was but she manhandled me and now I am sore.' I asked her if she knew what time she got up and she said it was early.			

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	Resident Z was rubbing her hip and lower stomach area. I went and reported this to my supervisor and we reported to [name of] Administrator." A document written by RN #2 in the grievance investigation, on 12/16/10, indicated in a typed time line/statement the following: "9:50 a.m.-Received report that resident was in need of an interview due to some concerns that had been voiced. 10:05 a.m.- Resident in activity at this time spoke with me briefly. Resident was asked if she was upset this AM by something. Resident stated that she was upset & someone was rushing with her this AM. I asked resident to speak with me after her activity was finished. 10:30 a.m.- Resident came to my office & stated that she needed to talk to me now. I asked resident to tell me about what had happened this AM that upset her. She proceeded to tell me that nobody was mean to her, but they were just rushing around when they got her dressed & up for the day- 'I felt like they were just man-handling me.' Resident stated that she was not mad & did not want anybody in trouble. She stated to just 'ask them to slow down & tell me what is going on.' Resident then stated that the girl that got her up today sat in her lap this morning			

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	when she was getting her ready for the day. Resident showed this nurse how someone had sat across her lap. Resident stated that she again did not want anyone in trouble about this--she stated maybe they were just rushing because of the snow outside. 10:45 a.m.- Skin assessment done... No complaints of pain...." CNA #2's written statement for this incident was as follows: "I and an oriente [sic] walked into room got clothes pan out went to hall to get supplies. Resident stated she didn't want to be washed. I said YES I washed her up got her transferred to w/c [wheel chair] stripped bed left room." RN #2, at 3:00 p.m. on 12/16/10, recorded five areas of work improvement with CNA #2 in regards to the above Resident Z allegations. None of Resident Z's allegations had been reported to State agencies and/or investigated thoroughly. The above interactions and/or work improvements for CNA #2 were not part of CNA #2 's employee record or work history. This federal tag relates to complaint			

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	number IN00086322. 3.1-28(a)			

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F0241 SS=E	Based on observation, interview and record review, the facility failed to ensure residents received prompt and appropriate response from staff when summoned by call light for assistance. This affected 5 of 8 interviewable residents within the 19 present who attended the group interview (Residents J, R, S, T, U) and 1 of 1 resident (Y) who was observed for call light response. Findings include: 1. The group interview was held on 2/22/11 at 3:00 p.m. Eight (8) of nineteen (19) residents present were identified as alert and oriented and interviewable, on the Resident Roster, provided by the Director of Nurses on 2/21/11 at 11:30 a.m. Five (5) of 8 residents indicated they had to wait for call lights to be answered (Residents J, R, S, T, U). One resident present, identified as interviewable, indicated the resident had waited 1 and 1/2 hours for an answer to the call light on occasion. Four residents, identified as interviewable, indicated they waited 30 minutes to an hour for call lights to be answered. 2. On 2/22/11 at 10:55 a.m., Resident Y's call light was observed to be on, for an unknown length of time. The light	F0241	1. All associates were inserviced on prompt and appropriate response when summoned by the call light for assistance.2. Licensed Nurses were inserviced on 3/8/11 regarding Policy/Procedure for use of the call light. Other facility staff were inserviced on 3/9/11 regarding Policy/Procedure for use of the call light. 3. Call light tracking & trending completed on each unit by the assigned cna on 3/10/11. Care guides updated to better anticipate residents needs based on tracking & trending results.4.Call light tracking & trending and interviewable resident interviews for response time will be conducted 3 times per week for 3 months, then 2 times per week for 3 months, then 1 time per week for 6 months by Nursing Admin. Audit findings will be reviewed by the PI Committeee monthly for 12 months. PI committee will determine need for further audits.	03/27/2011

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	remained on. LPNs #2 and #3 were observed outside the resident's room, and in and around the nurses' station, at 10:58-10:59 a.m., with the audible call light going on, and the light outside the resident's room on. At 11:00 a.m., LPN #3 entered the room. Resident Y indicated she wanted to get up out of bed. The LPN turned off the call light, indicated she would tell "the girls," and exited the room. No one returned to the room until 11:25 a.m. At 11:25 a.m., CNA #2 delivered the lunch tray to the resident's room. The resident indicated she had wanted to get up in the chair before lunch. The CNA indicated the resident was going to get a shower after lunch. A guest of the resident stated, "Can she not get up in the chair for lunch?" The CNA then assisted the resident to a bedside chair for her meal. The Resident Roster, provided by the Director of Nurses on 2/21/11 at 11:30 a.m., indicated Resident Y had a history of falls, incontinence, a decline in Activities of Daily Living, and problems with pain. On 2/24/11 at 2:00 p.m., the observation			

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	was reviewed with the Director of Nurses, LPN #1 and the Administrator. LPN #1 indicated Resident Y had been on CNA #2's assignment that day and everything was late, including getting people up. 3. The Policy and Procedure for the Use of Call Light [no date] was provided by the Director of Nursing on 2/23/11 at 11:45 a.m. The purpose was to respond promptly to resident's call for assistance. Procedural Steps included, but were not limited to, the following: "All facility personnel must be aware of call lights at all times." "Answer all call lights promptly whether or not you are assigned to the resident." "Answer all call lights in a prompt, calm, courteous manner; turn off the call light as soon as you enter the room." "Never make the resident feel you are too busy to give assistance; offer further assistance before you leave the room." This federal tag relates to complaint number IN00086322. 3.1-3(t)			

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F0282 SS=D	Based on observation, record review, and interview, the facility failed to provide each resident with care according to the written plan of care, for 1 of 17 sampled residents, in that a resident ambulated on his own in his room, when the care plan indicated he needed assistance. (Resident G) Finding includes: During the initial tour, on 2/21/11 at 9:45 a.m., RN #2 indicated Resident G was on a restorative program and was walked, with assistance, to and from the dining room for meals. She indicated, upon further interview, he did not have any mobility alarms, but used the call light when he wanted to go anywhere. Resident G's clinical record was reviewed on 2/21/11 at 2:00 p.m. The resident's most recent quarterly Minimum Data Set Assessment, dated 1/13/11, indicated the resident required extensive assistance of one for transfers and ambulation. The resident had a care plan, reviewed 1/13/11, indicating he was at risk for falls. The care plan indicated he was to be assisted to ambulate to and from the dining room daily at lunch and dinner with a gait belt and rolling walker. The care plan also indicated he was placed on	F0282	1. Rehab assessed resident G for safety with independent ambulating in his room. Care Plan & Care Guide updated.2. All Care Plans/Care Guides were audited for activity level accuracy. Updated as necessary. 3. Care Guides will be reviewed weekly and updated as necessary by Nuring Administration to maintain accuracy of activity level.4. Audits of Care Guides will be completed 3 times a week by assigned Department Heads for 3 months, then 2 times a week for 3 months, then 1 time a week for 6 months. Audits will be reviewed by the PI Committee monthly, for 12 months. PI committee will determine need for further audits. Plans will be updated as indicated.	03/27/2011

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	the facility's falling star program. The Daily Care Guide, the assignment sheet used by CNAs to guide care, was provided by RN #2 on 2/21/11 at 11:00 a.m. The Care Guide indicated Resident G "Requires assistance of one with all transfers, walking and bathing and dressing needs." Resident G was observed to be up in his bathroom, with his walker, by himself, on 2/22/11 at 9:15 a.m. He indicated he had walked in there to use the restroom. He was observed, again on 2/23/11 at 9:10 a.m., with his walker, standing in the bathroom adjusting his clothing. No one was in the bathroom with him, or in the room. RN #2 indicated, during interview on 2/25/11 at 10:30 a.m., Resident G was being reviewed again to see if he was safe to be up on his own in his room. She indicated the resident had needed assistance to get up from his chair the evening before. This federal tag relates to complaint number IN00086322 3.1-35(g)(2)			

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F0312 SS=D	Based observation, interview and record review, the facility failed to provide care to a resident who was unable to carry out activities of daily living, for 1 of 1 totally dependent resident [N] requiring isolation, in total sample of 17; in that, the resident had been incontinent of stool and not been provided perineal care in a timely manner, support hose were not applied as ordered and the resident was not assisted by two staff to move and transfer. Findings include: Resident N was observed on 2/21/11 at 10:15 a.m. LPN #1 indicated the resident was recovering from open heart surgery, had renal failure and was in isolation for Clostridium Difficile [C-Diff infection of the bowel tract] and that he required total care [extensive assistance]. The "Daily Care Guide" [CNA assignment form] was provided, on 2/21/11 at 10:55 a.m., by LPN #1. Resident N's interventions included the	F0312	1. CNA #2 was immediately suspended pending investigation. Nursing staff was inserviced on 2/22/11 by Staff Devlopment Coordinator regarding following the Care Guide as written.2. Interviews were conducted on 2/23/11 by the ADON with all interviewable residents being cared for by cna #2 regarding care and treatment performed by any associates. No allegations of mistreatment and/or roughness were reported during interviews.3. Nursing Department will observe 3 cnas on alternate shifts providing care, using checklist, each week to ensure appropriate care is provided per the Care Guide. Observations will be completed 3 times a week. 4. Audits will be completed by Nursing Admin. of observation checklist 3 times a week for 3 months, then 2 times a week for 3 months, then weekly for 6 months. Audits will be reviewed by the PI Committee monthly for 12 months. PI Committee will determine need for further audits. Plans will be updated as indicated.	

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	following: "I have had open heart surgery, remind me to use a pillow to splint my chest when I cough. I have several incisions on my chest- tell the nurse if they look different or like they are sore. I need assistance with transfers as I am only starting to recuperate from my surgery. [Listed to have 2 + person physical assistance.] I am more confused than when I was admitted." This same information was part of the residents care plan dated 12/15/10. Resident N was observed to receive a late partial bath on 2/22/11 at 2:45 p.m. CNA #2 was observed carrying clean linens to the resident's isolation room at that time. CNA #2 indicated she was going to clean him up for the day. At 2:50 p.m., the resident informed the CNA he thought his bowels had moved. She rang the call light for a stool specimen to be obtained. LPN #3 entered the room at 2:55 p.m. At that time, the resident was turned over from his back. The resident had been incontinent of bowel with a dark, drying ring 4-6 inches from the incontinent stool. Neither the LPN, nor the CNA would indicate when the resident was last turned and/or repositioned.			

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	The bath was then started. The resident was observed to be in bed with bilateral blue boots. Those were removed for skin care; support hose were then applied to legs. The support hose had not been on prior to that time. While receiving a partial bath, the CNA asked the resident to turn to the right side; he voiced complaints of pain in the right arm. While receiving skin care to the rectal area, he complained of pain and soreness each time the area was wiped. The area appeared excoriated and very red. A disposable brief was applied for the resident. Once the bath was completed, the CNA reached out her hands/arms to the resident. The resident was lying flat on his back and grabbed the CNA's hands; both pulled and tugged to get the resident in a sitting position on the edge of the bed. The resident would then lean back or to the side and could not hold his balance. The CNA continued her care of the resident alone. The CNA then applied a gait belt, the resident's shoes, and transferred the resident to the wheel chair. The CNA completed the task, emptied the trash, cleaned up the unit etc. Reporting of the pain of the arm, and excoriation was not observed prior to her leaving the			

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	unit. On 2/23/11 at 4:30 p.m., the clinical record was reviewed. The physician had ordered, on 1/28/11, 'TED hose [support hose] on at 8 :00 a.m. and off at HS [hour of sleep]," and on 2/4/11, "Magic Butt creme twice a day," was ordered for the excoriation of buttock area. The initial MDS [minimum data set] assessment, dated 12/8/10, recorded the resident as requiring extensive assistance of transfers, dressing, ambulation, bathing and hygiene. LPN #1, during an interview on 2/22/11 at 4:00 p.m., indicated the resident should have had two persons to transfer and not pulled up by the arms, due to post operation of heart surgery. This federal tag relates to complaint number IN00086322 3.1-38(a)(3)			